



Sign In Time: _____

Date: _____

Patient Information

(Please Print Legibly So That We May Serve You More Efficiently)

Last Name _____ First Name _____ Initial _____

Social Security Number _____ Date of Birth _____ Age _____

Drivers License State _____ DL # _____ Class _____ Other ID: _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____ Ext _____

Gender: Male Female Marital Status: Single Married

Emergency Contact: Name _____ Phone (____) _____

Private Patient Pay (If this box has been checked please DO NOT complete the Employer information)

Employer _____ Temp Agency: Y / N Hire Date: _____

Employer's Address _____ Phone (____) _____

Location/Store # _____ Supervisor _____

PURPOSE OF VISIT:

Injury on the Job? Yes No

Non-Injury Purposes: Yes No

Date of Accident: _____ At What Time: _____

- Reason:
- Pre-Placement
 - Annual/Biannual
 - HazMat/Environmental
 - Random
 - Post Accident
 - Other _____

Where were you (at work) when the accident occurred?

Area of body injured: _____

Right _____ Left _____

- What:
- Physical
 - DOT (CDL)
 - Drug Screen only
 - Physical and Drug Screen
 - Other _____

How did the accident occur?

I was... _____

You may contact my employer to verify the purpose of my visit if necessary. _____

Patient's Signature